

		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0039321</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Glenshire Nursing & Rehab Ctre</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>22660 South Cicero Avenue</u> <u>Richton Park</u> <u>60471</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____																									
Telephone Number: <u>(708) 747-6120</u> Fax # <u>(708) 747-6491</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One S. Wacker Drive, Suite 800, Chicago, IL 60606-3392</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>																									
IDPA ID Number: <u>363939906001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630																									
Date of Initial License for Current Owners: <u>3/23/1994</u>																											
Type of Ownership: <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input checked="" type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input checked="" type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>Charles J. Fischer</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of any audit adjustments to address above.																											

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre# 0039321 Report Period Beginning: 1/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>142</u>	Skilled (SNF)	<u>142</u>	<u>51,830</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>152</u>	Intermediate (ICF)	<u>152</u>	<u>55,480</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>294</u>	TOTALS	<u>294</u>	<u>107,310</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>35,047</u>	<u>1,077</u>	<u>6,763</u>	<u>42,887</u>	8
9	SNF/PED					9
10	ICF	<u>40,015</u>	<u>1,179</u>	<u>553</u>	<u>41,747</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>75,062</u>	<u>2,256</u>	<u>7,316</u>	<u>84,634</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 78.87%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/01/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 03/01/94NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 38and days of care provided 5,399Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number Glenshire Nursing & Rehab Ctr # 0039321 Report Period Beginning: 1/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	331,481	63,017	27,695	422,193		422,193		422,193		1
2	Food Purchase		492,571		492,571	(27,875)	464,696	(17,410)	447,286		2
3	Housekeeping	311,337	83,786		395,123		395,123		395,123		3
4	Laundry	130,524	13,451	33,107	177,082		177,082		177,082		4
5	Heat and Other Utilities			198,249	198,249		198,249	7,705	205,954		5
6	Maintenance	85,094	50,398	162,818	298,310		298,310	15,155	313,465		6
7	Other (specify):*										7
8	TOTAL General Services	858,436	703,223	421,869	1,983,528	(27,875)	1,955,653	5,450	1,961,103		8
	B. Health Care and Programs										
9	Medical Director			13,200	13,200		13,200		13,200		9
10	Nursing and Medical Records	3,336,562	697,114	82,127	4,115,803		4,115,803	(207,852)	3,907,951		10
10a	Therapy	142,015	2,894	301,160	446,069		446,069		446,069		10a
11	Activities	168,916	9,301	2,769	180,986		180,986		180,986		11
12	Social Services	150,311		11,043	161,354		161,354		161,354		12
13	Nurse Aide Training										13
14	Program Transportation			1,593	1,593		1,593		1,593		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,797,804	709,309	411,892	4,919,005		4,919,005	(207,852)	4,711,153		16
	C. General Administration										
17	Administrative	218,560		1,463,396	1,681,956		1,681,956	(1,463,396)	218,560		17
18	Directors Fees										18
19	Professional Services			137,482	137,482		137,482	(19,558)	117,924		19
20	Dues, Fees, Subscriptions & Promotions			54,209	54,209		54,209	1,179	55,388		20
21	Clerical & General Office Expenses	452,277	47,548	38,874	538,699		538,699	40,923	579,622		21
22	Employee Benefits & Payroll Taxes			710,689	710,689	27,875	738,564	59,406	797,970		22
23	Inservice Training & Education			4,067	4,067		4,067	526	4,593		23
24	Travel and Seminar							1,299	1,299		24
25	Other Admin. Staff Transportation			12,799	12,799		12,799	2,879	15,678		25
26	Insurance-Prop.Liab.Malpractice			184,922	184,922		184,922	100	185,022		26
27	Other (specify):*										27
28	TOTAL General Administration	670,837	47,548	2,606,438	3,324,823	27,875	3,352,698	(1,376,642)	1,976,056		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,327,077	1,460,080	3,440,199	10,227,356		10,227,356	(1,579,044)	8,648,312		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			81,278	81,278		81,278	506,942	588,220			30
31	Amortization of Pre-Op. & Org.			6,693	6,693		6,693	(6,693)				31
32	Interest							829,894	829,894			32
33	Real Estate Taxes							678,693	678,693			33
34	Rent-Facility & Grounds			2,034,145	2,034,145		2,034,145	(2,034,145)				34
35	Rent-Equipment & Vehicles			8,713	8,713		8,713	9,440	18,153			35
36	Other (specify):* Mortgage Ins.							57,662	57,662			36
37	TOTAL Ownership			2,130,829	2,130,829		2,130,829	41,793	2,172,622			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		269,798	17,547	287,345		287,345		287,345			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			160,968	160,968		160,968		160,968			42
43	Other (specify):* Non-Allowable			213,272	213,272		213,272	(213,272)				43
44	TOTAL Special Cost Centers		269,798	391,787	661,585		661,585	(213,272)	448,313			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,327,077	1,729,878	5,962,815	13,019,770		13,019,770	(1,750,523)	11,269,247			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Glenshire Nursing & Rehab Ctr# 0039321

Report Period Beginning:

1/01/2001

Ending:

12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(59,104)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(673)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment	(929)	43		19
20 Contributions	(5,200)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(195,202)	43		24
25 Fund Raising, Advertising and Promotional	(3,486)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(4,535)	43		28
29 Other-Attach Schedule See Attached Schedule F	(270,741)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (539,870)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense	(6,693)	31	33
34 Adjustments for Related Organization Costs (Schedule VII)	(1,203,960)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (1,210,653)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (1,750,523)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X	90,319	Ln39,C02	44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$ 90,319		47

SEE ACCOUNTANTS' COMPILATION REPORT

Glenshire Nursing & Rehab CtrID# 0039321Report Period Beginning: 1/01/2001Ending: 12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Reference	Sch. V Line
1	Adjust Mgt. Co. Medical Supplies "A" To Cost	\$ (157,504)	10	1
2	Adjust Mgt. Co. Medical Supplies "Other" To Cost	(50,348)	10	2
3	Adjust Mgt. Co. Food To Cost	(17,410)	2	3
4	Amortization of 2001 Deferred Maintenance	7,075	6	4
5	Non-Allowable Professional Fees	(47,741)	19	5
6	Defer 2001 Painting and Decorating	(1,566)	6	6
7	Patient Clothing	(3,247)	43	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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21				21
22				22
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32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(270,741)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Glenshire Nursing & Rehab Ctre# 0039321

Report Period Beginning:

1/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(17,410)	0	0	0	0	0	0	0	0	0	0	(17,410)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	7,705	0	0	0	0	0	0	0	0	7,705	5
6	Maintenance	5,509	0	9,646	0	0	0	0	0	0	0	0	15,155	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(11,901)	0	17,351	0	0	0	0	0	0	0	0	5,450	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(207,852)	0	0	0	0	0	0	0	0	0	0	(207,852)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(207,852)	0	0	0	0	0	0	0	0	0	0	(207,852)	16
	C. General Administration													
17	Administrative	0	0	(400,896)	(1,062,500)	0	0	0	0	0	0	0	(1,463,396)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(47,741)	0	27,183	0	1,000	0	0	0	0	0	0	(19,558)	19
20	Fees, Subscriptions & Promotions	0	0	1,179	0	0	0	0	0	0	0	0	1,179	20
21	Clerical & General Office Expenses	0	0	40,557	0	366	0	0	0	0	0	0	40,923	21
22	Employee Benefits & Payroll Taxes	0	0	59,406	0	0	0	0	0	0	0	0	59,406	22
23	Inservice Training & Education	0	0	526	0	0	0	0	0	0	0	0	526	23
24	Travel and Seminar	0	0	1,299	0	0	0	0	0	0	0	0	1,299	24
25	Other Admin. Staff Transportation	0	0	2,879	0	0	0	0	0	0	0	0	2,879	25
26	Insurance-Prop.Liab.Malpractice	0	0	100	0	0	0	0	0	0	0	0	100	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(47,741)	0	(267,767)	(1,062,500)	1,366	0	0	0	0	0	0	(1,376,642)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(267,494)	0	(250,416)	(1,062,500)	1,366	0	0	0	0	0	0	(1,579,044)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Glenshire Nursing & Rehab Ctr# 0039321

Report Period Beginning:

1/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	26,606	0	480,336	0	0	0	0	0	0	506,942	30
31	Amortization of Pre-Op. & Org.	(6,693)	0	0	0	0	0	0	0	0	0	0	(6,693)	31
32	Interest	(59,104)	0	35,788	0	853,210	0	0	0	0	0	0	829,894	32
33	Real Estate Taxes	0	0	9,378	0	669,315	0	0	0	0	0	0	678,693	33
34	Rent-Facility & Grounds	0	0	0	0	(2,034,145)	0	0	0	0	0	0	(2,034,145)	34
35	Rent-Equipment & Vehicles	0	0	9,440	0	0	0	0	0	0	0	0	9,440	35
36	Other (specify):*	0	0	0	0	57,662	0	0	0	0	0	0	57,662	36
37	TOTAL Ownership	(65,797)	0	81,212	0	26,378	0	0	0	0	0	0	41,793	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(213,272)	0	0	0	0	0	0	0	0	0	0	(213,272)	43
44	TOTAL Special Cost Centers	(213,272)	0	0	0	0	0	0	0	0	0	0	(213,272)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(546,563)	0	(169,204)	(1,062,500)	27,744	0	0	0	0	0	0	(1,750,523)	45

Facility Name & ID Number GlenShire Nursing & Rehab Ctr# 0039321

Report Period Beginning:

1/01/2001

Ending:

12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
<u>Sidney Glenner</u>	<u>80.00 %</u>	<u>GlenBridge Nursing & Rehabilitation Centre, Ltd</u>	<u>Niles</u>	<u>SEE ATTACHED SCHEDULE A</u>		
<u>Barry Ray</u>	<u>20.00 %</u>	<u>GlenCrest Nursing & Rehabilitation Centre, Ltd</u>	<u>Chicago</u>			
		<u>Glen Elston Nursing & Rehabilitation Centre, Ltd</u>	<u>Chicago</u>			
		<u>Glen Oaks Nursing & Rehabilitation Centre, Ltd</u>	<u>Northbrook</u>			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	<u>Total from Page 6A</u>	<u>400,896</u>	<u>Glen Health and Home Management, Inc.</u>	<u>A</u>	<u>231,692</u>	<u>(169,204)</u>	2
3	V							3
4	V	<u>Total from Page 6B</u>	<u>1,062,500</u>	<u>GlenBar Management Company, Ltd.</u>	<u>B</u>		<u>(1,062,500)</u>	4
5	V							5
6	V	<u>Total from Page 6C</u>	<u>2,034,145</u>	<u>GlenShire Real Estate and Development Limited Partnership</u>	<u>C</u>	<u>2,061,889</u>	<u>27,744</u>	6
7	V							7
8	V							8
9	V			<u>OWNERSHIP REFERENCE:</u>				9
10	V			<u>A: Owned 100.00 % by Sidney Glenner through attribution</u>				10
11	V			<u>B: Owned 80.00 % by Sidney Glenner & 20.00 % by Barry Ray</u>				11
12	V			<u>C: Owned 60.00 % (constructively) by Sidney Glenner & 20.00 % by Barry Ray</u>				12
13	V							13
14	Total		\$ <u>3,497,541</u>			\$ <u>2,293,581</u>	\$ * <u>(1,203,960)</u>	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre# 0039321Report Period Beginning: 1/01/2001Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 Management Fees	\$ 400,896	Glen Health and Home Management, Inc.	A	\$	\$ (400,896)
16	V	5 Utilities		Glen Health and Home Management, Inc.	A	7,705	7,705
17	V	6 Repairs and Maintenance		Glen Health and Home Management, Inc.	A	9,646	9,646
18	V	19 Professional Fees		Glen Health and Home Management, Inc.	A	27,183	27,183
19	V	20 Licenses, Permits and Inspection		Glen Health and Home Management, Inc.	A	1,179	1,179
20	V	21 Clerical		Glen Health and Home Management, Inc.	A	40,557	40,557
21	V	22 Employee Benefits and Payroll		Glen Health and Home Management, Inc.	A	59,406	59,406
22	V	23 Training and Education		Glen Health and Home Management, Inc.	A	526	526
23	V	32 Amortization of Mortgage Costs		Glen Health and Home Management, Inc.	A	2,178	2,178
24	V	25 Auto Expenses		Glen Health and Home Management, Inc.	A	2,879	2,879
25	V	26 Insurance		Glen Health and Home Management, Inc.	A	100	100
26	V	30 Depreciation		Glen Health and Home Management, Inc.	A	26,606	26,606
27	V	32 Interest		Glen Health and Home Management, Inc.	A	33,610	33,610
28	V	33 Real Estate Taxes		Glen Health and Home Management, Inc.	A	9,378	9,378
29	V	35 Equipment and Vehicle Rental		Glen Health and Home Management, Inc.	A	9,440	9,440
30	V	24 Travel		Glen Health and Home Management, Inc.	A	1,299	1,299
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 400,896			\$ 231,692	\$ * (169,204)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre# 0039321Report Period Beginning: 1/01/2001Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Administrative	\$ 1,062,500	GlenBar Management Company, Ltd.	B	\$	\$ (1,062,500)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,062,500			\$ 0	\$ * (1,062,500)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number GlenShire Nursing & Rehab Ctre# 0039321Report Period Beginning: 1/01/2001Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	21 Clerical	\$	GlenShire Real Estate & Development Limited Partnership	C	\$ 366	\$ 366
16	V	19 Bank Fees		GlenShire Real Estate & Development Limited Partnership	C	1,000	1,000
17	V	30 Depreciation		GlenShire Real Estate & Development Limited Partnership	C	480,336	480,336
18	V	32 Interest Income		GlenShire Real Estate & Development Limited Partnership	C	(53,025)	(53,025)
19	V	32 Interest Expense		GlenShire Real Estate & Development Limited Partnership	C	893,987	893,987
20	V	33 Real Estate Taxes		GlenShire Real Estate & Development Limited Partnership	C	669,315	669,315
21	V	34 Rental Income	2,034,145	GlenShire Real Estate & Development Limited Partnership	C		(2,034,145)
22	V	32 Amortization of Mortgage Costs		GlenShire Real Estate & Development Limited Partnership	C	12,248	12,248
23	V	36 Mortgage Insurance Premium		GlenShire Real Estate & Development Limited Partnership	C	57,662	57,662
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 2,034,145			\$ 2,061,889	\$ * 27,744

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Sidney Glenner	President	Administrative	80.00 %	111,762	13	22.30 %	Salary	\$ 28,238	Ln 17, Col 1	1
2	Barry Ray	Vice President	Administrative	20.00 %	59,873	9	22.30 %	Salary	15,128	Ln 17, Col 1	2
3	David Glenner	Vice President	Administrative	0.00 %	83,822	9	22.30 %	Salary	21,179	Ln 17, Col 1	3
4											4
5											5
6			See Schedule B								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 64,545		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre# 0039321

Report Period Beginning:

1/01/2001Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Glen Health & Home Management, Inc.
 Street Address 5454 West Fargo Avenue
 City / State / Zip Code Skokie, IL 60077
 Phone Number (847) 674-5454
 Fax Number (847) 674-8311

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	419,563	5	\$ 38,195	\$ 84,634	\$ 7,705	1
2	6	Repairs and Maintenance	Patient Days	419,563	5	47,817	84,634	9,646	2
3	19	Professional Fees	Patient Days	419,563	5	134,756	84,634	27,183	3
4	20	Licenses, Permit and Inspection	Patient Days	419,563	5	5,844	84,634	1,179	4
5	21	Clerical	Patient Days	419,563	5	201,055	84,634	40,557	5
6	22	Employee Benefits and Payroll	Patient Days	419,563	5	294,500	84,634	59,406	6
7	23	Training and Education	Patient Days	419,563	5	2,609	84,634	526	7
8	32	Amortization of Mortgage Costs	Patient Days	419,563	5	10,795	84,634	2,178	8
9	25	Auto Expenses	Patient Days	419,563	5	14,271	84,634	2,879	9
10	26	Insurance	Patient Days	419,563	5	498	84,634	100	10
11	30	Depreciation	Patient Days	419,563	5	131,894	84,634	26,606	11
12	32	Interest	Patient Days	419,563	5	166,618	84,634	33,610	12
13	33	Real Estate Taxes	Patient Days	419,563	5	46,491	84,634	9,378	13
14	35	Equipment and Vehicle Rental	Patient Days	419,563	5	46,797	84,634	9,440	14
15	24	Travel	Patient Days	419,563	5	6,440	84,634	1,299	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,148,580	\$		\$ 231,692	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre # 0039321 Report Period Beginning: 1/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Allfirst Mortgage Corporation		X	Mortgage	\$179,447.81	3/16/96	\$ 12,973,600	\$ 11,380,014	4/01/2018	.0775	\$ 893,987	1
2	Allfirst Mortgage Corporation		X	Amortization of mortgage costs							12,248	2
3							Mortgage interest allocated from Management Comp:				35,788	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				\$179,447.81		\$ 12,973,600	\$ 11,380,014			\$ 942,023	9
	B. Non-Facility Related*											
10									Interest Income Offset:		(112,129)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$ (112,129)	14
15	TOTALS (line 9+line14)						\$ 12,973,600	\$ 11,380,014			\$ 829,894	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Glenshire Nursing & Rehab Ctr**# **0039321**

Report Period Beginning:

1/01/2001

Ending:

12/31/2001**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																																				
1. Real Estate Tax accrual used on 2000 report.		\$ 671,000	1																																	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 658,315	2																																	
3. Under or (over) accrual (line 2 minus line 1).		\$ (12,685)	3																																	
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 682,000	4																																	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																																	
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																																	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 669,315	7																																	
Real Estate Tax History:																																				
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1996</td><td>601,797</td><td>8</td></tr> <tr><td>1997</td><td>624,000</td><td>9</td></tr> <tr><td>1998</td><td>642,858</td><td>10</td></tr> <tr><td>1999</td><td>648,110</td><td>11</td></tr> <tr><td>2000</td><td>658,315</td><td>12</td></tr> </table>	1996	601,797	8	1997	624,000	9	1998	642,858	10	1999	648,110	11	2000	658,315	12	<table border="1"> <tr><td colspan="2">FOR OHF USE ONLY</td><td></td></tr> <tr><td>13</td><td>FROM R. E. TAX STATEMENT FOR 2000</td><td>\$</td><td>13</td></tr> <tr><td>14</td><td>PLUS APPEAL COST FROM LINE 5</td><td>\$</td><td>14</td></tr> <tr><td>15</td><td>LESS REFUND FROM LINE 6</td><td>\$</td><td>15</td></tr> <tr><td>16</td><td>AMOUNT TO USE FOR RATE CALCULATION</td><td>\$</td><td>16</td></tr> </table>	FOR OHF USE ONLY			13	FROM R. E. TAX STATEMENT FOR 2000	\$	13	14	PLUS APPEAL COST FROM LINE 5	\$	14	15	LESS REFUND FROM LINE 6	\$	15	16	AMOUNT TO USE FOR RATE CALCULATION	\$	16
1996	601,797	8																																		
1997	624,000	9																																		
1998	642,858	10																																		
1999	648,110	11																																		
2000	658,315	12																																		
FOR OHF USE ONLY																																				
13	FROM R. E. TAX STATEMENT FOR 2000	\$	13																																	
14	PLUS APPEAL COST FROM LINE 5	\$	14																																	
15	LESS REFUND FROM LINE 6	\$	15																																	
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16																																	
See Attached Schedule G For Calculation Of 2001 Real Estate Tax Accrual.																																				

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Glenshire Nursing & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0039321

CONTACT PERSON REGARDING THIS REPORT Charles J. Fischer

TELEPHONE (312) 634-3400 FAX #: (312) 634-5518

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u>31-34-100-012-0000</u>	<u>22660 S. Cicero Ave, Richton Park II</u>	<u>\$ 658,314.50</u>	<u>\$ 658,314.50</u>
2. <u>See attached schedule for home office allocation</u>		<u>\$ 59,795.55</u>	<u>\$ 9,378.00</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>718,110.05</u>	\$ <u>667,692.50</u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A.
Square Feet:
91,624

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories
Four

C.
Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D.
Does the Operating Entity?

☒ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E.
List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F.
Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient Care	146,800	1994	\$ 300,792	1
2	Allocated from Management Company:			22,320	2
3	TOTALS	146,800		\$ 323,112	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctr

0039321

Report Period Beginning:

1/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	294		1994	1981	\$ 11,663,928	\$	30	\$ 388,798	\$ 388,798	\$ 3,045,581	4
5											5
6	Alloc from										6
7	Mgt Comp				404,357						7
8	ScheduleJ										8
	Improvement Type**										
9	Building Improvements		1994		78,204	7,820	10	7,820		58,653	9
10	Building Improvements		1995		107,573	10,757	10	10,757		71,715	10
11	Custom built 3rd floor nurses station		1995		6,595	660	10	660		3,740	11
12	Time delay egress locks and keypad		1995		3,550	355	10	355		2,011	12
13	Chimney		1995		1,016	102	10	102		578	13
14	Wall bumpers		1995		7,713	771	10	771		4,370	14
15	Room conversion - remodeling cos		1996		7,024	702	10	702		3,978	15
16	Electrical outlets and circuits		1997		18,500	1,850	10	1,850		8,633	16
17	Electrical outlets and circuits - dialysis room		1997		2,950	295	10	295		1,377	17
18	Air cleaner		1997		1,375	138	10	138		642	18
19	Fluorescent and incandescent lights		1997		9,775	978	10	978		4,562	19
20	Waste removal pump		1997		993	99	10	99		463	20
21	Boiler		1997		3,169	317	10	317		1,479	21
22	Food freezer floor		1997		2,700	270	10	270		990	22
23	New elevator clutch assembly		1997		1,644	164	10	164		602	23
24	Heat exchange for boiler		1997		2,392	239	10	239		877	24
25	Gazebo		1998		10,528	1,053	10	1,053		3,860	25
26	Fire sprinkler system repairs		1998		1,604	160	10	160		588	26
27	Security system		1998		1,917	192	10	192		703	27
28	Storage tank		1998		4,875	488	10	488		1,788	28
29	Elevator repairs		1998		2,706	271	10	271		993	29
30	HVAC replacements		1998		3,855	386	10	386		1,414	30
31	Hydraulic repack on all elevators		1998		2,500	250	10	250		917	31
32	Replace water heater		1998		2,697	270	10	270		989	32
33	Chain link fencing		1998		2,010	201	10	201		737	33
34	Elevator repairs		1998		2,747	275	10	275		1,008	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number Glenshire Nursing & Rehab Ctre

0039321

Report Period Beginning:

1/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Therapy room remodeling: drywall, electrical closet, piping	1998	\$ 8,525	\$ 853	10	\$ 853	\$	\$ 2,274	37	
38	Dialysis room: kitchen area	1998	2,757	276	10	276		735	38	
39	10-B label fire rated doors	1999	4,376	438	10	438		1,168	39	
40	Install cooling units in elevator and MDS office	1999	11,649	1,165	10	1,165		2,428	40	
41	Mini-blinds	1998	1,565	157	10	157		574	41	
42	November 30, 1998 credit	1998	(1,755)	(176)	10	(176)		(469)	42	
43	Add suction & liquid filters to compressor	2000	3,982	398	10	398		597	43	
44	Replace wood fence	2000	2,300	230	10	230		345	44	
45	Asphalt & striping project	2000	8,365	836	10	836		1,254	45	
46	Metal doors, install lighting by staircase	2000	6,010	601	10	601		902	46	
47	Install alarm with keypad at front door	2000	1,177	118	10	118		177	47	
48	Furnish & install 9,000 BTU mini air-conditioner system	2000	2,200	220	10	220		330	48	
49	Install ceramic tiles	2000	1,373	138	10	138		207	49	
50	Power rinse tank for dish washing machine	2001	2,594	130	10	130		130	50	
51	Rebuild condenser water pump	2001	5,198	260	10	260		260	51	
52	Install two grey boxes and mixing valves	2001	4,111	206	10	206		206	52	
53	Install portable chiller	2001	2,891	145	10	145		145	53	
54	Provide panel and circuiting to feed 20 dialysis receptacles	2001	10,914	546	10	546		546	54	
55	Circulating pump	2001	3,385	169	10	169		169	55	
56	Exterior lock doors	2001	3,423	171	10	171		171	56	
57									57	
58									58	
59									59	
60									60	
61									61	
62	Allocated from Management Company:		32,189			2,823	2,823	18,341	62	
63	See Attached Schedule K								63	
64									64	
65									65	
66									66	
67									67	
68									68	
69									69	
70	TOTAL (lines 4 thru 69)		\$ 12,476,126	\$ 35,944		\$ 427,565	\$ 391,621	\$ 3,253,738	70	

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Glenshire Nursing & Rehab Ctr

0039321

Report Period Beginning:

1/01/2001

Ending:

12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,297,019	\$ 139,882	\$ 139,882	\$	5,10 years	\$ 905,752	71
72	Current Year Purchases	114,366	5,718	5,718		10 years	5,718	72
73	Fully Depreciated Assets	32,861				5 years	32,861	73
74	Allocated from Management Company:	162,702	14,154	14,154			77,457	74
75	TOTALS	\$ 1,606,948	\$ 159,754	\$ 159,754	\$		\$ 1,021,788	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Allocated from Management Company:			\$ 14,951	\$ 901	\$ 901	\$		\$ 12,678	76
77										77
78										78
79										79
80	TOTALS			\$ 14,951	\$ 901	\$ 901	\$		\$ 12,678	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 14,421,137	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 196,599	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 588,220	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 391,621	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,288,204	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease

N/A

N/A

N/A

9. Option to Buy:

☐

YES

☒

NO

Terms: N/A

*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES

☒ NO

16. Rental Amount for movable equipment: \$ 10,565

Description:

Copier\$5,445, Ice-maker\$1,395, Postage meter\$664, Medical equip\$1,207, Mgt Co Allocation\$1,851

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Allocated from Management Company:</u>		\$	\$ <u>7,588</u>	17
18					18
19					19
20					20
21	TOTAL		\$	\$ <u>7,588</u>	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending

Annual Rent

12. /2002

\$

13. /2003

\$

14. /2004

\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO * It is the policy of this facility of hire only certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
					Units	Cost				
1	Licensed Occupational Therapist	Ln 10a,Col 2&3	hrs	\$	3,016	\$ 123,673	\$ 1,563	3,016	\$ 125,236	1
2	Licensed Speech and Language Development Therapist	Ln 10a, Col 3	hrs		746	30,573		746	30,573	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10a,Col 2&3	hrs		2,587	111,239	382	2,587	111,621	4
5	Physician Care	Ln 39, Col 3	visits			30			30	5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39, Col 2	# of prescripts				179,479		179,479	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Ln 39, Col 2					90,319		90,319	12
	Respiratory Therapy	Ln 10a, Col 1	4734 hrs	142,015				4,734	142,015	
13	Other (specify): Radiology&Laboratory	Ln 39, Col 3				16,767			16,767	13
14	TOTAL			\$ 142,015	6,349	\$ 282,282	\$ 271,743	11,083	\$ 696,040	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 742,516	\$ 2,450,771	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,024)	3,379,440	3,379,440	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,414	115,451	6
7	Other Prepaid Expenses	580	580	7
8	Accounts Receivable (owners or related parties)	(28,273)	(28,273)	8
9	Other(specify): <u>Employee Loans Receivable</u>	7,409	7,409	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,198,086	\$ 5,925,378	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		323,112	13
14	Buildings, at Historical Cost		12,068,285	14
15	Leasehold Improvements, at Historical Cost	372,363	407,841	15
16	Equipment, at Historical Cost	528,859	1,621,899	16
17	Accumulated Depreciation (book methods)	(412,310)	(4,288,204)	17
18	Deferred Charges		5,964	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds		430,948	21
22	Other Long-Term Assets (specify) <u>Goodwill</u>	49,163	49,163	22
23	Other(specify): <u>Mortgage Costs (Net)</u>		198,523	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 538,075	\$ 10,817,531	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,736,161	\$ 16,742,909	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 57,343	\$ 57,343	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	61,638	61,638	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	199,692	199,692	30
31	Accrued Taxes Payable (excluding real estate taxes)	8,411	8,411	31
32	Accrued Real Estate Taxes(Sch.IX-B)		682,000	32
33	Accrued Interest Payable		73,496	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Attached Schedule E:</u>	1,471,847	1,471,847	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,798,931	\$ 2,554,427	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,380,014	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>Due To Officers</u>	3,427,500	3,427,500	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,427,500	\$ 14,807,514	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 5,226,431	\$ 17,361,941	46
47	TOTAL EQUITY (page 18, line 24)	\$ (490,270)	\$ (619,032)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,736,161	\$ 16,742,909	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 401,820	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 401,820	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(892,090)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (892,090)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (490,270)	24

* Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Glenshire Nursing & Rehab Ctr

0039321

Report Period Beginning: 1/01/2001

Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 11,572,867	1
2	Discounts and Allowances for all Levels	(1,864,104)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,708,763	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	738,555	6
7	Oxygen	574,145	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,312,700	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	249,356	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	79,095	19
20	Radiology and X-Ray	4,698	20
21	Other Medical Services	692,286	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,025,435	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	59,104	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 59,104	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	21,678	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 21,678	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,127,680	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	1,983,528	31
32	Health Care	4,919,005	32
33	General Administration	3,324,823	33
B. Capital Expense			
34	Ownership	2,130,829	34
C. Ancillary Expense			
35	Special Cost Centers	500,617	35
36	Provider Participation Fee	160,968	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,019,770	40
41	Income before Income Taxes (line 30 minus line 40)**	(892,090)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (892,090)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Glenshire Nursing & Rehab Ctre**# **0039321**Report Period Beginning: **1/01/2001**Ending: **12/31/2001**

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,704	1,835	\$ 53,492	\$ 29.15	1
2	Assistant Director of Nursing	1,883	2,075	50,566	24.37	2
3	Registered Nurses	35,813	38,356	848,361	22.12	3
4	Licensed Practical Nurses	52,053	55,024	1,003,273	18.23	4
5	Nurse Aides & Orderlies	113,800	122,787	1,111,262	9.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,972	7,475	142,015	19.00	7
8	Rehab/Therapy Aides	10,615	11,169	133,092	11.92	8
9	Activity Director	1,831	1,931	21,368	11.07	9
10	Activity Assistants	18,415	20,070	147,548	7.35	10
11	Social Service Workers	13,356	14,536	150,311	10.34	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	3,912	4,051	35,768	8.83	14
15	Cook Helpers/Assistants	36,153	37,655	295,713	7.85	15
16	Dishwashers					16
17	Maintenance Workers	7,967	8,452	85,094	10.07	17
18	Housekeepers	33,813	38,130	311,337	8.17	18
19	Laundry	15,796	17,364	130,524	7.52	19
20	Administrator	5,725	6,139	115,389	18.80	20
21	Assistant Administrator	5,005	5,349	38,626	7.22	21
22	Other Administrative	1,612	1,612	64,545	40.04	22
23	Office Manager					23
24	Clerical	37,993	40,418	452,277	11.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,642	5,090	50,727	9.97	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Ward Clerks</u>	4,731	5,351	85,789	16.03	33
34	TOTAL (lines 1 - 33)	413,791	444,869	\$ 5,327,077 *	\$ 11.97	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 27,695	Ln 1, Col 3	35
36	Medical Director	Monthly	13,200	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	2,040	Ln 10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	64	2,769	Ln 11, Col 3	44
45	Social Service Consultant	248	11,043	Ln 12, Col 3	45
46	Other(specify)				46
47	Medical Librarian	48	2,010	Ln 10, Col 3	47
48					48
49	TOTAL (lines 35 - 48)	360	\$ 58,757		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	555	\$ 12,763	Ln 10, Col 3	50
51	Licensed Practical Nurses	637	13,375	Ln 10, Col 3	51
52	Nurse Aides	4,516	51,939	Ln 10, Col 3	52
53	TOTAL (lines 50 - 52)	5,708	\$ 78,077		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctre

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount				
Sidney Glenner	Administrative	80.00 %	\$ 28,238	Workers' Compensation Insurance	\$ 72,647	IDPH License Fee	\$ 200				
Barry Ray	Administrative	20.00 %	21,179	Unemployment Compensation Insurance	51,612	Advertising: Employee Recruitment	19,211				
David Glenner	Administrative	0.00 %	15,128	FICA Taxes	380,769	Health Care Worker Background Check	1,393				
Tonya Hackney	Administrator	0.00 %	115,389	Employee Health Insurance	113,253	(Indicate # of checks performed <u>199</u>)					
Diane Johnson	Asst Administrator	0.00 %	38,626	Employee Meals	27,875	Employment Fees	15,950				
				Illinois Municipal Retirement Fund (IMRF)*		Illinois Council on Long Term Dues	10,713				
				Union Health and Welfare	31,840	JCAH Accreditation Survey Fees	5,195				
				Uniform Allowance	4,680	Elevator, Equipment Inspection Fees	771				
				401K Match	2,840	Secr of State Annual Report, Permits	776				
				Profit Sharing	44,185	Allocated from Management Company:	1,179				
				Employee Appreciation, Gifts, Awards, Bonus	8,863	Less: Public Relations Expense	()				
				Allocated from Management Company:	59,406	Non-allowable advertising	()				
				See Attached Schedule D:		Yellow page advertising	()				
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 218,560	TOTAL (agree to Schedule V, line 22, col.8)	\$ 797,970	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 55,388				
(List each licensed administrator separately.)											
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees							
Description			Amount	Description	Line #	Amount					
Management Fees (eliminated in Column 7)			\$ 1,463,396								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 1,463,396								
(Attach a copy of any management service agreement)											
C. Professional Services				G. Schedule of Travel and Seminar**							
Vendor/Payee	Type		Amount								
Health Data Systems, Inc.	Computers		\$ 15,460								
Advanced Information Mgt.	Computers		5,468								
American Express Tax Services	Accounting		16,633								
Frost, Ruttenberg & Rothblatt	Accounting		1,047								
Sachnoff & Weaver, Ltd.	Legal		41,483								
Admiral Insurance Co.	Legal		4,649								
Littler Mendelson	Legal		15,695								
Personnel Planners, Inc.	Unemployment Consulting		3,740								
Commitment Consulting	A/R Collections		32,489								
Pro Tech Systems, Ltd.	Maintenance Consulting		818								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$					
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 137,482								

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

(continued from previous page)													
1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Repairs & Maintenance	1998	\$ 5,362	3years	\$ 894	\$ 1,787	\$ 1,787	\$ 894	\$	\$	\$	\$	\$
2	Painting & Decorating	1999	12,667	3years		2,111	4,222	4,222	2,112				
3	Painting & Decorating	2000	5,094	3years			849	1,698	1,698	849			
4	Painting & Decorating	2001	1,566	3years				261	522	522	261		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 24,689		\$ 894	\$ 3,898	\$ 6,858	\$ 7,075	\$ 4,332	\$ 1,371	\$ 261	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Glenshire Nursing & Rehab Ctr

STATE OF ILLINOIS

0039321

Report Period Beginning:

1/01/2001

Ending:

Page 23

12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care \$10,713
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 45,176 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 160,968
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 27,875 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? Yes
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider I.D. # 0039321
12/31/01

SCHEDULE A

SCHEDULE VII. RELATED PARTIES
Part A. Col.3

3 OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
Glen Health & Home Management, Inc.	Skokie	Management Company
GlenBar Management Company, Ltd.	Skokie	Management Company
GlenShire Real Estate & Development Limited Partnership	Skokie	Building Lessor
Fargo Real Estate & Development, LLC	Skokie	Building Lessor - Management Company
Therapy Masters	Skokie	Therapy company
GlenCare At Home, Ltd.	Skokie	Home Health agency
GlenCare Home Health, Ltd.	Skokie	Home Health agency
GlenCare Private Duty, Ltd.	Skokie	Home Health agency

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, LTD.
 Provider # 0039321
 12/31/2001

SCHEDULE B

SCHEDULE VII RELATED PARTIES

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

Name	Compensation Received From Other Nursing Homes				Total
	Glen Elston Nursing & Rehab. Centre, Ltd.	GlenCrest Nursing & Rehab. Centre, Ltd.	Glen Oaks Nursing & Rehab. Centre, Ltd.	GlenBridge Nursing & Rehab. Centre, Ltd.	
Sidney Glenner	12,978	34,048	33,208	31,528	111,762
David Glenner	6,953	18,240	17,790	16,890	59,873
Barry Ray	9,734	25,536	24,906	23,646	83,822
Total compensation received from other Nursing Homes	29,664	77,824	75,904	72,064	255,456

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider # 0039321
12/31/01

XIX. SUPPORT SCHEDULES

SCHEDULE C

C. Professional Services
Page 21

DESCRIPTION	AMOUNT
Total Schedule V, Line 19, Col. 3	<u>137,482</u>
Allocated from Management Co:	
Sachnoff & Weaver, Ltd. - Legal Services	4,490
American Express - Accounting Services	19,247
Schiller, Klein & McElroy - Legal Services	766
Frost, Ruttenberg - Accounting Services	632
Chuhak & Tecson - Legal Services	297
Lasko & Kocol - Legal Services	692
Ross Hardies - Legal Services	184
Architectural Dynamics - Engineering Services	<u>875</u>
Total allocated from Management Co:	<u>27,183</u>
Allocated from GlenShire Real Estate LLC - Bank Trust Fees	1,000
Non-allowable Professional Fees:	
Sachnoff & Weaver, Ltd.	(14,252)
Commitment Consulting	(32,489)
LaSalle Bank	<u>(1,000)</u>
Total Non-allowable Professional Fees	<u>(47,741)</u>
Total adjustments page 21, Sch C.	<u><u>(19,558)</u></u>
Total Schedule V, line 19, column 8	<u><u>117,924</u></u>

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider # 0039321
12/31/01

SCHEDULE D

XIX. SUPPORT SCHEDULES

D. Employee Benefits and Payroll Taxes
Page 21

DESCRIPTION	AMOUNT
Allocated from Management Co.	
FICA taxes	21,098
FUTA	373
SUTA	687
401K Match	2,971
Insurance - Hospital	22,634
Other Employee Benefits	2,375
Workers Compensation Insurance	1,194
Profit Sharing Plan Contribution	8,074
Total allocated from Management Co.	59,406

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider # 0039321
12/31/01

SCHEDULE E

XV. SUPPORT SCHEDULES

Page 17, Line 36

DESCRIPTION	AMOUNT
Refunds Exchange	8,443
Accrued Wage Assignment	-2,634
Credit Union	-430
Sundry Payable	232,557
Accrued Union Dues	6,607
Accrued Management Fees	277,083
Accrued Profit Sharing	64,500
Due to Third Party	885,922
Due Con. Mutual	-415
Due To Prior Owner	214
Total, Page 17, Line36	<u>1,471,847</u>

See Accountants' Compilation Report

GlenShire Nursing and Rehabilitation Centre, Ltd.
Provider # 0039321
12/31/01

SCHEDULE F

PAGE 5, SCHEDULE VI. ADJUSTMENT DETAIL
Schedule A. Nonallowable Expenses
Line 29 - Other Non-allowable costs

<u>Description</u>	<u>Amount</u>	<u>Reference</u>
Patient Reimbursement	(3,247)	43
Non-allowable professional fees	(47,741)	19
Adjust mgt. co. med supplies - med'a' to cost	(157,504)	10
Adjust mgt. co. med supplies - 'other' to cost	(50,348)	10
Defer 2001 painting & decorating	(1,566)	6
Amortization of current year deferred maintenance	7,075	6
Adjust mgt. co. food to cost	(17,410)	2
Total	<u>(270,741)</u>	

See Accountants' Compilation Report

GlenShire Real Estate & Development, LLC
Accrued Real Estate Taxes
12/31/01

SCHEDULE G

	Accrued 1/1/2001	Payments	Expense	Accrued 12/31/2001
Balance @ 1/01/01	(671,000.00)		(671,000.00)	
2000 real estate taxes paid		658,314.50	658,314.50	
Estimated 2001 real estate taxes:				
2000 taxes	658,314.50			
Estimated increase	3.50%			
Estimated 2000 taxes	681,355.51			
USE	682,000.00		682,000.00	(682,000.00)
Totals	(671,000.00)	658,314.50	669,314.50	(682,000.00)

Real estate tax history:

Year	Amount	Increase	
		\$	%
1991	443,164.00		
1992	465,682.00	22,518.00	5.08%
1993	529,742.00	64,060.00	13.76%
1994	545,165.38	15,423.38	2.91%
1995	582,936.44	37,771.06	6.93%
1996	601,796.63	18,860.19	3.24%
1997	624,000.41	22,203.78	3.69%
1998	642,857.87	18,857.46	3.02%
1999	648,110.27	5,252.40	0.82%
2000	658,314.50	10,204.23	1.57%

See Accountants' Compilation Report

Cell: C17

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GlenShire Nursing and Rehabilitation Centre, Ltd.
 Provider I.D. #0039321
 December 31, 2001

SCHEDULE H

Page 3, Schedule V, Line 23, Col. 8
 Inservice Training and Education

Training Material or Person(s) Attending	Date Attended	Location	Title Sponsor / Vendor	Total Cost
Colleen Kamin	1/24/2001	Oak Lawn	OBRA Surveys: Provider Protection Strategies	75
F. Harris	1/04/01	Facility	CNA Training Materials - Books	27
Margaret Caulker	1/04/01	Facility	CNA Training Materials - Books	47
Joceline Sikes, Vanetta Willis	1/10/2001	Facility	CNA Training Materials - Books	73
Lisa Velez	1/24/2001	River Grove	36-Hour Basic Orientation Course For Activity Directors	320
Y. Ogunlowo	1/04/01	Facility	CNA Training Materials - Books	51
Laura Caulker	1/04/01	Facility	CNA Training Materials - Books	62
Glenda Chappell	1/04/01	Facility	CNA Training Materials - Books	51
Colleen Kamin, K. Johnson	10/10/2001	Oak Lawn	The New MI Regulations - A Detailed Review Of IDPH Subpart S	300
Colleen Kamin	5/11/2001	Oak Lawn	Successful Marketing Through Relationship Building	30
Colleen Kamin, K. Johnson	5/02/01	Oak Lawn	Lawsuit Protection Plan, Part II: Wound Management	300
CNA Staff	3/26/2001	Facility	Prentice Hall - CNA Staff Books	820
Bola Ogunirinola	10/12/2001	Chicago	Cynthia Chow & Associates - Pathways To Success	80
Mel Puckett	10/09/01	Chicago	Chicago Southland Chamber of Commerce- Human Resource Seminar	200
Colleen Kamin	11/14/2001	Oak Lawn	Resident Abuse	125
Colleen Kamin, K. Johnson	7/17/2001	Oak Lawn	Where Is My 2299: An Insider's Guide To Cook Co. Medical Field Operations	200
Colleen Kamin, K. Johnson	6/14/2001	Oak Lawn	OSHA Requirements - 2001 Update	250
Mary Chapman	10/17/00,10/18/00	Oak Lawn	MDS 2.0 Competency And Certification (2 Day)	340
Stephen Budick	4/12/2000	Oak Lawn	MDS 2.0 Update - 2000	125
Stephen Budick	7/26/2000	Oak Lawn	Survey Citations, Immediate Jeopardy And IDR	125
Cathi Carlson	7/26/2000	Oak Lawn	Survey Citations, Immediate Jeopardy And IDR	125
Chris Kozminski	10/17/00,10/18/00	Oak Lawn	MDS 2.0 Competency And Certification (2 Day)	340
Inservice Training and Education				4,067
Management Company Allocation				526
TOTAL INSERVICE TRAINING AND EDUCATION				4,593

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Comment: Formula failed to convert

GlenShire Nursing and Rehabilitation Centre, LTD.
Provider #0039321
12/31/2001

SCHEDULE I

Page 3, Schedule V, Line 25, Col 8
Other Admin. Staff Transportation

	Gasoline	Licenses/ Stickers	Repairs	Mileage Reimb.	Total
Direct Expense	0	0	1,156	11,643	12,799
Allocated from Management Company					2,879
TOTAL	0	0	1,156	11,643	15,678

See Accountants' Compilation Report

**HEALTH AND HOME MANAGEMENT, INC.
ALLOCATION OF MANAGEMENT COMPANY BUILDING**

SCHEDULE J

ASSET DESCRIPTION	COST 6/30/1999	ADJUSTMENTS TO CAPITAL PROJECTION	ADJUSTED CAPITAL PROJECTION 6/30/1999	ADDITIONS 7/1/99- 12/31/2000	COST 12/31/2000	NURSING HOME PERCENTAGE 84.9438%	GLENBRIDGE 103,052/460,292 0.223883969	GLENCREST 111,372/460,292 0.241959452	GLEN OAKS 101,895/460,292 0.221370348	GLEN ELSTON 41,220/460,292 0.08955185	GLENSHIRE 102,753/460,292 0.223234382
1996 BUILDING PURCHASE	230,000		230,000		<u>230,000</u>	195,371	43,740	47,272 #	43,249 #	17,496	43,613
1998 BUILDING RENOVATION											
GENERAL CONTRACTOR	957,570		957,570		957,570						
ELECTRICAL CONTRACTOR	275,576		275,576		275,576						
HVAC CONTRACTOR	182,130		182,130		182,130						
PLUMBING CONTRACTOR	68,599		68,599		68,599						
ARCHITECT FEES	115,968		115,968		115,968						
OTHER FEES AND PERMITS	33,024		33,024		33,024						
SECURITY SYSTEM	17,953		17,953		17,953						
TELEPHONE SYSTEM	12,500		12,500		12,500						
MISC. BUILDING COMPONENTS	24,226	-15,261	24,226		24,226						
CAPITALIZED INTEREST	121,387		106,126		106,126						
LANDSCAPING	30,000		30,000		30,000						
SPRINKLER SYSTEM	10,720	-24,749	10,720		10,720						
HVAC SYSTEMS	24,749	-10,235	0								
WALL CONSTRUCTION	10,235	-10,634	0								
ELECTRICAL	10,634	-26,075	0								
MISC. IMPROVEMENTS	26,075	-5,900	0								
ASPHALT DRIVEWAY	5,900		0								
					<u>1,834,392</u>	1,558,202	348,857	377,022 #	344,940 #	139,540	347,844
1999 ACCORD ELECTRIC				17,929	17,929						
HMS + ASSOCIATES-INTERIOR				31,505	31,505						
SAM MORMINO-LANDSCAPING				1,050	1,050						
ARCHITECTURAL DYNAMICS-ARCHITECT FEES				1,468	1,468						
MISC.				11,076	11,076						
					<u>63,028</u>	53,538	11,986	12,954 #	11,852 #	4,794	11,952
2000 AQUATIC WORKS - BUILT-IN FISH TANK				5,000							
					<u>5,000</u>	4,247	951	1,028 #	940 #	380	948
2001 NO ADDITIONS											
					<u>2,132,420</u>	<u>1,811,359</u>	<u>405,534</u>	<u>438,276</u>	<u>400,981</u>	<u>162,210</u>	<u>404,357</u>

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